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Hispanic Subgroup Utilization Patterns at an Inner-City Community Mental Health Center

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HISPANIC SUBGROUP UTILIZATION PATTERNS AT AN INNER-CITY COMMUNITY MENTAL HEALTH CENTER

by

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VITA

The author, Silas Gregory Gilliam, is the son of Silas W. and Eula (Ison) Gilliam. He was born June 29, 1958, in Wise County, Virginia.

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CHAPTER I

INTRODUCTION

One of the major goals of community mental health programs has been the enhanced provision of needed services to lower class and ethnic minority clients who have previously been underserved. The evidence that Hispanic clients, who are disproportionately poor, continue to underutilize mental health services and receive inferior and/or unresponsive services in this country has, therefore, been a concern among many clinicians and researchers.

Attempts to explain the apparent problems in delivering needed services to Hispanic populations have included the speculations that Hispanics may, in fact, have a culturally influenced lower prevalence rate of psychological disorders, or may utilize alternatives to the institutionalized mental health system as sources of emotional support. It has been the general consensus, however, that the most powerful barriers to adequate and effective mental health care for Hispanics are institutional and therapist characteristics, such as the lack of bilingual/bicultural staff, therapist class and cultural biases, and the failure to accommodate treatment approaches to the cultural needs and expectations of Hispanic clients.

One common implicit assumption in the literature has been that the various Hispanic populations in this country are culturally homogeneous, so that community and treatment programs designed to enhance the attractiveness and effectiveness of mental health services for one Hispanic subgroup are of equal appropriateness for another. However, some have argued that there are significant sociocultural differences among the different Hispanic subgroups. Whether Hispanic subgroups may utilize available mental health services differently, as a possible reflection of this, has not yet been assessed.

Statement of the Problem

It is the purpose of this study to compare the utilization patterns of different Hispanic subgroups at an inner-city community mental health center where bilingual/bicultural services are provided. Mexican American, Puerto Rican, Cuban, Central American, and South American clients will be compared on demographics, referral patterns, presenting problems, treatment modalities received, number of agency contacts, and type of termination from treatment. As research comparing the mental health service utilization patterns of these Hispanic subgroups has not heretofore been conducted, this study is considered exploratory in nature and the analyses will address the null hypothesis in each instance.

CHAPTER II

REVIEW OF THE LITERATURE

This literature review has five sections. In the first section the literature which has addressed mental health service utilization and the Hispanic population as a whole is discussed. Occasional reference is made to mental health service utilization by Asians, Native Americans, and Afro-Americans in comparison to the utilization patterns of Hispanics. The second, third, and fourth sections, respectively, discuss the literature which has specifically addressed the mental health service utilization patterns of Mexican Americans, Puerto Ricans, and Cubans. No literature was found pertaining to the utilization of mental health services by Central Americans or South Americans in the United States. The reasons for a lack of mental health service literature regarding the status of persons from Spanish-speaking Central America or South America may be the relatively smaller overall populations and lower population densities of these groups in this country. These factors could conceivably operate to command less research attention toward these groups. The fifth section is a critique of the proposed directions for research and program development to improve the adequacy

and responsiveness of mental health services for the Hispanic populations in this country.

Community Mental Health Service and the Hispanic Population

The problem. The Hispanic population in the United States, comprised of approximately nine million Mexican Americans, two million Puerto Ricans, eight hundred thousand Cubans, and three millon people of other Hispanic origins, represents the second largest minority group in this country. Taken together these groups constitute 6.4% of the total population (U.S. Bureau of Census, 1980). Karno and Edgarton (1969) and Torrey (1972) have suggested that because the Hispanic population as a whole is only partially acculturated and marginally integrated economically, its members are subject to a number of high-risk indicators for potential psychological disturbance. These indicators include: a) poor communication skills in English; b) the poverty cycle--limited education, low income, depressed social status, deteriorated housing, and minimal political influence; c) the survival of traits from a rural agrarian culture that are relatively ineffectual in an urban technological society; d) the necessity of seasonal migration (for some); and e) the stressful problem of acculturation to a society that appears prejudicial, hostile, and rejecting. In a review of the available literature on mental health service delivery to the

Hispanic population in the United States, Padilla, Ruiz, and Alvarez (1975) have concluded, nevertheless, that Hispanics receive extremely poor mental health care. The severity of the problem seemed enough for them to assert that Hispanics receive mental health care "of a different kind, of lower quality, and in lesser proportions than any other ethnically identifiable population" (p. 892).

Underutilization of services. One of the most consistent findings in the literature on the mental health service utilization by Hispanics has been that of Hispanic underrepresentation in treatment populations. Jaco (1960) surveyed the incidence rate of mental disorders during a period from 1951 to 1952 in Texas and reported a lower frequency of the use of private and public mental hospitals by Mexican Americans. Similarly, Karno and Edgarton (1969) found that while Mexican Americans made up 9%-10% of California's state population in 1962-1963, the percentage of Mexican Americans receiving treatment was underrepresentative of their population by 6.6% to 9.1%, depending on type of facility.

Abad, Ramos, and Boyce (1974) found Puerto Ricans to be underrepresented at the Connecticut Mental Health Center during 1971-1972. In that period admissions and readmissions of Puerto Ricans were at least 3.5 times lower than that of Afro-Americans, a group comparable in terms of poverty and minority status.

In a study of community mental health service delivery to several ethnic minority groups (Asian Americans, Mexican Americans, Afro-Americans, and Native Americans) over a three-year period at 17 Seattle area community mental health centers, Sue (1977) found Mexican Americans and Asian Americans to be several times underrepresented while Afro-Americans and Native Americans were heavily overrepresented.

Only one study that was found reported Hispanics to be proportionately represented in a treatment population. Andrulis (1977) reported Mexican Americans, Anglos, and Afro-Americans to have representative populations in a major community mental health center in northwest San Antonio. Importantly, the center's catchment area population was nearly 40% Mexican American and its professional and non-professional staff included personnel who were bilingual/bicultural.

Type and quality of service. A number of past studies have demonstrated Hispanic clients to be accepted less often for more intensive treatment modalities and more likely to prematurely terminate therapy. Yamamoto, James, and Palley (1968) presented data on the outpatient psychiatric care of 594 men and women from four groups: 387 Anglos, 149 Afro-Americans, 53 Mexican Americans, and five Orientals. In comparison to the Anglo controls, the Mexican Americans were referred for individual or group psychotherapy less

often and received less lengthy and intensive treatment (i.e., terminated sooner or were not recommended for continued sessions).

Karno (1966) obtained similar findings in a study conducted at the outpatient clinic of the Neuropsychiatric Institute, UCLA. Having reviewed the case records of Afro-American, Anglo, and Mexican American clients he reported that prospective ethnic clients were less likely to be accepted for treatment than nonethnic clients. In addition, he found that the ethnic clients, once accepted, received less and shorter term psychotherapy than nonethnic clients of the same social class characteristics. Karno concluded, "Ethnicity tends to be avoided by clinic personnel" (p. 520).

More recent studies, however, have suggested that Hispanics as a group may now be receiving equal, but unresponsive services from this country's community mental health system. Sue, Allen, and Conaway (1978) in a study of mental health services to Mexican Americans and Native Americans at 17 community mental health centers in and around Seattle found no evidence that Mexican Americans or Native Americans were rendered inferior or discriminatory services. When compared with Anglos no significant overall differences emerged in regard to type of therapy program, specific treatment service, or type of personnel seen. However, significant differences did occur in these groups'

rates of failing to return for treatment after the initial session. Mexican Americans failed to return at a rate of 42%, and Native Americans at a rate of 55%, while Anglos failed to return at a rate of 30%. After controlling for demographic variables, Native Americans were still more likely to drop out after the first session while the Mexican American rate approached significance. Similarly, Andrulis' (1977) study in San Antonio, while finding all groups to be proportionately represented in relation to their catchment area populations, found Mexican Americans, and to a lesser extent, Afro-Americans, to drop out prematurely when compared with Anglos. In this study drop out was inferred from the groups' percentages of terminations against medical advice, and types of services rendered or personnel seen were not examined.

Proposed solutions. Several researchers have argued that more precise understandings of Hispanic culture are necessary if the development of more adequate and responsive service delivery to this population is to occur. Sue et al. (1978) concluded that while the demonstration of equity of service may indicate progress in the mental health system's ability to respond to the needs of minority groups, the continued alarmingly high incidence of drop out among ethnic group members indicates the important need for developing more responsive services based upon considerations of differences in culture, lifestyles, and experiences.

Likewise, Andrulis (1977) argued that a more detailed familiarization with the culture of Hispanics may be necessary before more effective treatment may occur.

Padilla et al. (1975) have delineated a number of factors which may account for Hispanics receiving disproportionate and/or unresponsive community mental health care. These factors include: a) geographic inaccessibility to community mental health centers; b) language barriers between Hispanic clients and mental health professionals; c) therapist class-bound values which dissuade Hispanic clients from continued mental health treatment; and d) therapist culture-bound values which may lead to misunderstandings or misdiagnoses of Hispanic clients. The factors pertaining to language, class, and culture in particular were considered by Padilla et al. (1975) to interact in a way to actively discourage Hispanic clients from using community mental health services. This was seen to occur much in the same way that Lorion (1973, 1974) and Cobb (1972) in reviews of studies of lower income clients have concluded that race and social class of the therapist seem to affect a client's response to treatment, and that an effective and appropriate approach to a problem based on middle-class values may be totally inappropriate and ineffective for a client returning to a lower class environment. Padilla et al.'s (1975) recommendations for improvement of service to the Hispanic population included:

a) educating mental health professionals about the culture and lifestyles of Hispanic clients; b) increasing the number of bilingual/bicultural staff members; c) increasing the number of students from Hispanic subgroups in the mental health professions; d) adapting treatment interventions to specific cultural characteristics of the Hispanic subgroups; and e) developing innovative programs to reach out and involve members of the Hispanic community in community mental health center programs.

Summary. As can be seen, utilization research indicating disproportionate, inferior, or apparently unresponsive services to the Hispanic population in the United States has led to proposed solutions that involve increasing mental health professionals' awareness of the characteristics of Hispanic culture, and developing culturally sensitive programs in order that services may be more effectively matched to client needs and expectations. In examining the above research and proposed solutions it is also apparent that members of the Hispanic population in this country are often considered to be one group, culturally and socioeconomically. Indeed, Padilla et al. (1975) stated

> In spite of geographic and in some cases racial differences between the Spanish Speaking/Surnamed subgroups, all share cultural and socioeconomic similarities that allow us to speak here with relative ease of the Spanish Speaking/Surnamed as a homogeneous group (p. 892).

Moreover, researchers rarely have partialed out effects for

socioeconomic status and other demographic variables when comparing utilization patterns of mental health services of Hispanic groups to those of Anglos and other ethnic groups. Virtually none have investigated cultural and socioeconomic variables as sources of differences within the Hispanic population itself.

A number of articles and studies exist in the literature which examine the utilization of mental health services by separate subgroups within the Hispanic population in the United States. Some suggest that all Hispanic subgroups should not be considered culturally equal in regard to the understanding of utilization problems or to the development of culturally sensitive treatment strategies. Studies which explicitly examine Hispanic subgroups separately will be reviewed in the next three sections.

Mexican Americans

Acosta (1977, 1979) has written that the Mexican is subject to special conditions of psychological stress. In addition to poverty and discrimination as consistent life stressors, language and acculturative factors create additional burdens Mexican Americans must face as a minority group. Reviewing the evidence indicating that such negative conditions are associated with greater incidence and prevalence of psychiatric disorders, he claimed that it is a paradox that Mexicans are markedly underrepresented in mental health facilities (Acosta, 1979). Concern about this

apparent underutilization of services has been the framework in which much of the research on Mexican Americans' mental health service utilization patterns has been conducted. Within this framework three problem areas have received most attention: a) the prevalence of mental illness among Mexican Americans; b) the use of ethnic community support systems for help with emotional problems; and c) the relationship between mental health service utilization and Mexican American subculture (Keefe & Casas, 1980).

Prevalence of mental illness among Mexican Americans. Research concerned with mental illness among Mexican Americans has generally been conceived along one of two perspectives. In the first approach investigators have used the evidence of underutilization to conclude that Mexican Americans experience a true lower prevalence of psychological disorders (Jaco, 1960; Madsen, 1969).

Despite a scarcity of empirical evidence, several investigators have strongly challenged this view, citing the non-universality of underutilization from one center to another (Keefe & Casas, 1980); and claiming that it is counterintuitive to assume, given this group's high risk situation in this society, that it would experience a lower overall prevalence of psychopathology (Padilla & Ruiz, 1973).

Roberts (1980), in one of the few population-based empirical studies addressing this question, compared

indices of psychological distress among Mexican Americans, Afro-Americans, and Anglos after surveying residents of Alameda County, California. No differences occurred among the ethnic groups in reported emotional or mental illness, and negative affect. Mexican Americans, however, reported significantly less satisfaction with leisure and marriage, and less positive affect than Anglos, but somewhat more satisfaction and positive affect than Afro-Americans. Adjustments for demographic and socioeconomic factors reduced, but did not eliminate, the ethnic differences. Roberts concluded that the prevalence of psychological distress among Mexican Americans is at least as high as in the overall population, and in some respects higher, at least in Alameda County.

The second approach to examining mental illess among Mexican Americans has taken the position that Mexican Americans not only have emotional problems, but that certain disorders may occur more frequently among Mexican Americans than other ethnic groups. This approach has usually compared incidence rates of psychological disturbances for Mexican Americans to Anglos, but a few studies have involved comparisons with other ethnic groups. No studies were found comparing the psychological disturbance rates of Mexican Americans with those of other Hispanic subgroups.

The results of the studies examining culturally related differences in psychological symptoms have been

inconclusive. Supportive of the contention that ethnic differences are reflected in rates of psychopathology are studies such as those by Fabrega, Swartz, and Wallace (1968) and Pokorny and Overall (1970).

Fabrega et al. (1968) analyzed data of 141 schizophrenics consisting of three independently drawn samples of Anglos (80), Afro-Americans (42), and Mexican Americans (19) in Texas state hospitals. They concluded that even when the ethnic groups were matched with respect to socioeconomic levels, the Mexican American schizophrenics were more chronic, regressed, and disorganized. Pokorny and Overall (1970), with a 10% sample of the Texas state hospital psychiatric population, found more mental disorganization, mental distortion, withdrawal, retardation, motor distortion, and depression among Mexican Americans than among Afro-American or Anglo patients.

In contrast, Sue (1977) found no differences with respect to mental retardation, organic brain syndrome, psychosis, neurosis, personality disorder, psychophysiological problems, transient situational problems, and behavior disorders for Mexican Americans, Native Americans, and Asian Americans when compared to Anglos. Afro-Americans, on the other hand, did show an overall difference.

In addition to studies emphasizing psychopathological symptoms or diagnoses, differences between Mexican Americans and Anglos have been found with respect to substance abuse

and suicide rates. Drug abuse rates among urban Mexican youth have been shown to be higher and suicide rates lower for Mexican Americans when compared to Anglos (Keefe & Casas, 1980; Padilla, Padilla, Morales, Olmedo, & Ramirez, 1977). In a review of studies of Mexican American mental health Keefe and Casas (1980) have concluded that, in fact, these findings concerning drug abuse and suicide rates are among the few conclusions that safely can be drawn in regard to Mexican American-Anglo differences. This, they asserted, is due to serious methodological problems which question the validity and reliability of past studies attempting to identify psychopathological differences across cultures. One such problem has been that of many researchers failing to delineate the methods used to identify the Hispanic subgroup of the sample (self-identification, staff identification, Spanish surname) making it difficult to assess the "ethnic purity" or representativeness of the sample.

Mexican American community support systems. A number of reviewers have critically examined the evidence for alternative sources of emotional support that have been suggested to be factors in Mexican Americans' underutilization of formal mental health services. Keefe and Casas (1980), Roll, Millen, and Martinez (1980), and Acosta (1977) have discussed the great importance of the extended family as a source of support for Mexican Americans. The extended family as an important support system has been

shown to persist across many Mexican American subgroups (urban vs. rural; acculturated vs. unacculturated; low vs. high income) and it has been suggested that, being closed systems, Mexican American families may tolerate higher degrees of abnormal behavior from family members before outside help is sought. Indirect empirical support for this notion has been pointed out in studies such as Pokorny and Overall's (1970) investigation which demonstrated Mexican American schizophrenics to be more chronic, regressed, and disorganized, suggesting that delays in seeking help had occurred. Andrulis (1977) also supplied supportive evidence for this by showing that Mexican Americans have fewer family referrals than Anglos.

There has also been evidence that Mexican Americans may seek help from physicians (Acosta, 1977, 1979) and clergymen (Keefe & Casas, 1980) rather than from mental health professionals. Barrera (1978) has warned against this explanation for underutilization, however, since it has not been clearly demonstrated that Mexican Americans overutilize these sources for emotional problems in comparison to other groups.

A fourth alternative source of support that has received much attention in the literature has been Mexican Americans' reliance on "curanderismo" or the folk medical complex. While this has been a popular explanation for underutilization (Roll et al., 1980), Acosta (1979),

Barrera (1978), and Keefe and Casas (1980) have all cited evidence indicating that few Mexican Americans continue to seek help from "curanderos" or faith healers, and those who do often seek treatment from physicians or mental health professionals as well. These authors have thus rejected the popular belief that "curanderismo" serves as an explanation for Mexican American underutilization of mental health services.

Mental health services and the Mexican American subculture. While some researchers (Kline, 1969; Torrey, 1972) have suggested that Mexican Americans perceive mental health centers as alien and hostile and therefore are unlikely to turn to them for help with emotional problems, others have rejected this explanation for underutilization. Acosta and Sheehan (1976), Karno and Edgarton (1969), and Keefe, Padilla, and Carlos (1978) have shown Mexican Americans to have positive feelings and attitudes about professional mental health services. Moreover, Acosta and Sheehan (1976) demonstrated Mexican American students to have a generally higher opinion of the utility of psychotherapy than Anglo students, and to rate Anglo professionals as having more skill than Mexican American professionals. Acosta and Sheehan suggested that because Mexican Americans have few professional role models to identify with, Mexican American professionals may not yet be seen as highly credible by Mexican Americans. The finding does not offer an

explanation for underutilization, however.

Karno and Edgarton (1969) have also demonstrated that Mexican Americans show very little difference from Anglos in their perceptions and definitions of mental illness, arguing against the notion that Mexican Americans may differ in their recognition of mental illness, and thus differ in their help seeking behavior on that basis.

The most frequently proposed explanations for Mexican American underutilization of mental health services concern institutional characteristics and policies that exclude Mexican Americans or inhibit them from seeking service. These include language barriers, social class, and cultural differences between Hispanic clients and mental health professionals who are mainly Anglo and middle-class, a tendency to overdiagnose psychopathology when treating Mexican Americans, the absence of community input and involvement in organizing and administrating mental health services, and reluctance to develop and implement innovative programs (Acosta, 1979; Barrera, 1978; Keefe & Casas, 1980; Roll et al., 1980).

Some empirical evidence does exist that indicates that the introduction of Spanish speaking, indigenous personnel increases the utilization of services in Mexican American communities (Heiman & Kahn, 1975; Kahn & Heiman, 1979).

Roll et al. (1978) have written that Mexican Americans' preference for an affective rather than cognitive

approach to life, tendency toward a passive coping style, and their cultural values of "personalismo" (preference and trust for people rather than institutions), familism, and "machismo," need to be recognized and integrated into treatment approaches when serving this population. Acosta (1979) further argued that it must be kept in mind, when formulating treatment programs for Mexican Americans, that other Hispanic subgroups may differ from Mexican Americans and from each other in their ethnic identities, socioeconomic backgrounds, and mental health needs.

Summary. Research investigating Mexican American patterns of mental health service utilization has focused on the underutilization phenomenon and attempts to account for its occurrence. Recent reviewers have concluded that underutilization cannot reasonably be explained by Mexican Americans' use of folk medicine, or by the existence of a lower prevalence of psychological disorders in the Mexican American population. The question of whether Mexican Americans, relative to other ethnic groups, experience a higher rate of certain types of psychological disorders because of cultural differences has been raised. However, few conclusions can easily be drawn because of methodological problems in the studies involved. It appears that high rates of drug abuse among Mexican American youth and lower overall suicide rates have been the most firmly established findings.

Explanations for underutilization that have been given the most support have been Mexican Americans' comparatively high degree of reliance upon the extended family as a source of emotional support, and characteristics of the mental health system which tend to act as barriers to utilization because of social class, language, and cultural biases.

No studies were found which investigated the utilization patterns or therapeutic outcomes of mental health service utilization of Mexican Americans relative to other Hispanic subgroups, although it has been recognized that Mexican Americans may differ culturally and socioeconomically from other Hispanic subgroups.

Puerto Ricans

Few empirical studies specifically investigating the utilization of mental health services by Puerto Ricans have been conducted. A more common trend in the literature has been that of authors, when discussing Puerto Rican mental health service utilization, to generalize from studies of Mexican Americans (Delgado & Scott, 1979; Rosado, 1980). There has been a call in the literature from authors speaking on Puerto Rican mental health for a stop to the common practice of regarding Hispanic subgroups as culturally homogeneous, and for an increase in understanding the specific needs and cultural characteristics of Puerto Rican clients. Arce (1982) has asserted

Each [group] has its own lifestyle; social context;

> idiosyncratic patterns of thinking, feeling, and behaving; and particular strengths and weaknesses. The factors motivating Hispanic migration to the United States are also clearly different for each group. While all groups face basically similar problems in American society and have a limited number of choices among alternatives, each arrives at different solutions. In spite of the process of acculturation, the "Puerto Ricanness" of the Puerto Rican, the "Cubanness" of the Cuban, and the "Mexicanness" of the Mexican American continue to be visible in verbal expressions, coping styles, patterns of interpersonal interaction, and health-seeking behavior (p. 462).

Similarly, Gomez (1976) has argued for the need to interpret the behavior and mental health needs of Hispanics through specific "cultural filters." He stated that the label Spanish-speaking is not enough to identify and define the different populations sharing a common language, for,

> It is evident that class, political ideology and experiences, family and social structures, economic needs, and migratory patterns and other factors motivating emigration to the United States are not the same for Puerto Ricans, the Cubans, the Mexican Americans, and other people coming from Central and South America (p. 65).

Mental health services and the Puerto Rican subculture. The status of Puerto Ricans on the mainland United States has been described in bleak terms; as a group they are poorly educated, usually work in low-paying, menial occupations or are unemployed, and suffer from prejudice and culture and language barriers (Christensen, 1975; Gomez, 1976). In addition, emigration often results in severe blows to the traditionally paternalistic and authoritarian extended Puerto Rican family structure (Montijo, 1975).

It has been hypothesized that a disproportionate

number of lower-class Puerto Rican clients have not participated in traditional systems of therapy largely because they lacked traits Anglo middle-class therapists have been shown to find desirable in clients, i.e., being White, attractive, verbal, intelligent, and successful (Rosado, 1980). In addition, Rosado has identified several psychocultural areas of dissimilarity between the typical middle-class Anglo client and the lower-class Puerto Rican client that, if ignored, could lessen therapists' effectiveness with the lower-class Puerto Rican client. Rosado suggested that Puerto Ricans, when compared to Anglos, tend to prefer a present time orientation, external or supernatural conceptual-explanatory models of emotional disturbance, and a passive and respectful interactive mode. Rosado also indicated that Puerto Ricans may expect immediate and concrete results from the therapeutic process.

Christensen (1975) also delineated a number of values and traits linked to the Puerto Rican ethos which may be important in understanding Puerto Ricans' attitudes toward and expectations from mental health service providers, and which would need to be considered in the development of service programs to enhance utilization. Chief among these were fatalism; "respeto" and "dignidad," which concern the dignity of an individual and respect for those deserving of it; "machismo," generally referring to the superior role of men; and "humanismo," an idealistic and spiritual type

of humanism.

The empirical studies which have examined Puerto Rican concepts of appropriate mental health service utilization have, in general, seemed to support these authors' contentions. Torres (1980), in surveying 74 Puerto Rican and Anglo residents in Chelsea, Massachusetts, found the Puerto Ricans significantly more likely than the socioeconomically matched Anglo Americans to view the nonamelioration of a client who has visited a psychiatrist for five weekly sessions as evidence of psychiatrist failure or ineffectiveness. The Puerto Ricans showed a significantly greater tendency than the Anglos to disregard expert health service after symptom relief, and differed from Anglos by seeing emotional problems either more or just as appropriately helped by religion than by a psychiatrist. The Puerto Ricans were also found to be significantly more inclined than Anglos to view a relationship between a female client and male therapist in which the client disclosed intimate concerns and expressed emotion toward the therapist as an unexpected, unhelpful, and strange use of a therapist. Puerto Ricans were particularly more inclined than Anglos to disapprove specifically of the intimate self-disclosure occurring in the relationship.

In a study of the cultural attitudes toward mental illness and utilization of mental health service among Puerto Rican migrant women, Gil (1980) found the Puerto

Rican women to perceive mental health services as impersonal, and as failing to take into consideration the Puerto Rican cultural values of "personalismo" (personalism), "respeto" (respect), "dignidad" (dignity), "bondad" (kindness), and "caridad" (charity). Spiritualism and the use of folk healers was found to be a significant source of support for the women in the sample, regardless of their rate of utilization of mental health services. Level of acculturation to the dominant United States culture was found to be the most significant variable in the utilization of mental health services by the Puerto Rican women, with those exhibiting a higher frequency of utilization having higher levels of education and longer residence in the United States.

While no empirical studies were found investigating the overall frequency or types of psychological disturbances presented by Puerto Ricans, Rabkin (1979) found Puerto Rican psychiatric hospitalization rates in New York City's 338 health areas from 1969-1971 to vary inversely with the density of the Puerto Rican population in those areas. This relation could not be accounted for by poverty, lack of family cohesiveness, or population mobility. Rabkin speculated that the variables that may have contributed to the effect of ethnic density were exposure to stressful events, availability of social buffers which modify the impact of such exposure, personal and social resources, self-selected

mobility of residents, age structure, and community response to disturbed and disturbing behavior.

Gomez (1976) has anecdotally reported that alcoholism, drug addiction, psychosomatic illnesses, broken families, and other self-destructive behaviors are prevalent among Puerto Ricans in the United States. Montijo (1975) has suggested that Puerto Rican males generally view the need for psychotherapy as a sign of weakness, and that Puerto Rican women may evidence conflicts surrounding dependency needs and exhibit psychosomatic symptomatology.

Summary. Little research has been conducted examining the utilization patterns of mental health services by Puerto Ricans in the continental United States, in terms of utilization rates, referral patterns, symptomatology, types of services received, or therapeutic outcomes. There has been a call in the literature to consider the cultural characteristics and experience of Puerto Ricans as separate from other Hispanic subgroups, and a number of authors have anecdotally described the socioeconomic and cultural characteristics of Puerto Ricans living in the United States. Empirical studies investigating Puerto Rican attitudes toward mental health service utilization have generally been supportive of these proposed cultural characteristics' import to mental health service delivery. One of the few studies examining acculturation level and mental health service utilization was conducted with Puerto Rican women

and indicated that acculturation was highly predictive of utilization. While no studies known to this author have examined prevalence rates of psychological disturbance among Puerto Ricans, it has been suggested that alcoholism, drug abuse, psychosomatic concerns, and family discord are prevalent in the Puerto Rican population.

Cubans

No empirical studies investigating the utilization of mental health services by Cubans in the United States were identified by this author. However, Szapocznik, Scopetta, Aranalde, and Kurtines (1978) and Szapocznik, Kurtines, and Hanna (1979) investigated cultural differences between Cuban immigrants and Anglos in nonclinical and clinical populations. These differences were considered to have implications for the development of culturally sensitive modes of treatment for this population. In a nonclinical adolescent sample of Cubans and Anglos in Miami, the Cubans preferred a lineal relationship to other people (relationships determined by relative positions within a hierarchy), while Anglos preferred an individualistic orientation (autonomous relating to others as opposed to relating along hierarchical or lateral networks). The Cubans also preferred subjugation to nature, present time orientations, and not to endorse idealized human values (peace, harmony, spiritual development, and egalitarian social systems), whereas Anglos tended to prefer mastery over nature, future time orientations,

and to endorse idealized human values (Szapocznik et al., 1978). These findings were replicated with an adult clinical population in Miami, with the exception that the differences in the groups for the endorsement of idealized human values did not reoccur (Szapocznik et al., 1979).

Taking the stance that in order for psychosocial treatment to be effective with a client population, it must be sensitive to the cultural characteristics of that population, Szapocznik, Scopetta, and King (1978) outlined a treatment approach which utilized these findings in a way to attain mutuality of patient-therapist expectations for treatment with Cubans. The primary features of this approach included: a) the need for the therapist to relate hierarchically with the client, to take the role of authority figure and to assume responsibility for the therapeutic system; b) the need for therapeutic interventions to include reorganization of family structure and other outside environmental sources of client functional impairment when necessary; c) the need for treatment to be present oriented and to utilize crisis to promote personal growth and the restructuring of interpersonal relations; and d) the need for treatment to focus on concrete and obtainable treatment objectives.

Summary. No empirical studies specifically addressing the mental health service utilization patterns of Cuban immigrants in this country were identified. However, there

has been documented evidence of psychocultural differences between Cubans and Anglo Americans that have been seen as having implications for the development of culturally sensitive treatment approaches for Cuban clients. How the actual patterns of mental health service utilization by Cubans compare to those of Anglos, other ethnic groups, or of other Hispanic subgroups has not been empirically assessed.

Critique and Statement of the Problem

A consistent theme in the literature relevant to the utilization of mental health services by Hispanic populations is that these populations' needs have been underserved, and that corrective actions on the part of the mental health community need to occur in order to make responsive and effective services more available to them. The proposed corrective measures universally involve increasing mental health professionals' knowledge of Hispanic socioeconomic and cultural characteristics in order to reduce stereotypes and biases, increasing the numbers of bilingual/bicultural professional and nonprofessional staff in our facilitites, and the formulation of treatment approaches and modalities that will respect and correspond to the culturally influenced needs and expectations of Hispanic clients. These proposals for matching client needs and treatment methods are in line with Lorion's (1974) view that alternative treatment procedures can and should be utilized to enhance

treatment effectiveness with lower socioeconomic groups.

Discussions of the specific socioeconomic and cultural characteristics of Hispanic clients that need to be investigated and incorporated by mental health professionals in order to reach these ends have generally included attention to the fact that Hispanic clients are disproportionately poor and have lower educational levels than Anglos. These factors in and of themselves have been seen to result in low acceptance and high attrition rates for disadvantaged clients entering therapy (Cobb, 1972; Lorion, 1973), and to cause "cultural" differences between low-income clients and middle-class therapists that adversely affect the attractiveness and effectiveness of psychotherapy for low-income clients (Lorion, 1974).

In addition to these educational and economically related factors, however, there has been a call in the literature for increased understandings of specifically Hispanic characteristics that need to be addressed in developing effective treatment approaches. In this realm there is an issue that has yet to be addressed in the empirical literature; namely, whether it is valid to assume that different Hispanic subgroups utilize mental health services in similar culturally influenced ways. If it is true, as some have asserted, that there are important sociocultural differences among the different Hispanic subgroups, it is conceivable that such differences could lead to different

referral patterns (i.e., different routes by which clients come for help), expectations of the psychotherapeutic process, types of problems presented, or responses from service delivery systems. Such information would be helpful and important to service providers in designing outreach or community relations programs, and in developing therapeutic strategies in ways to most effectively match client needs and expectations with appropriate culturally sensitive interventions.

It is the purpose of this study to examine and compare the utilization patterns of different Hispanic subgroups at an inner city community mental health center where bilingual/bicultural services are provided. Demographic data, referral patterns, presenting problems, treatment modalities received, length of stay, and type of termination from treatment will be examined for Mexican Americans, Puerto Ricans, Cubans, Central Americans, and South Americans who have received services at Edgewater Uptown Community Mental Health Center (EUCHMC) in Chicago, Illinois. As research comparing the mental health service utilization patterns of these separate Hispanic subgroups has not heretofore been conducted, this study is considered exploratory in nature and the analyses will address the null hypothesis in each instance.

CHAPTER III

METHOD

Subjects

The subjects were 155 adult clients of Hispanic origin/descent. All had been seen on an outpatient basis through the Ethnic Services Program of Edgewater Uptown Community Mental Health Center (EUCMHC) in Chicago, Illinois. Of the total, 35 were Puerto Rican, 39 were Mexican, 25 were Cuban, 26 were Central American, and 30 were South American. Fifty-nine percent of the clients were female, the median age was 30, approximately one-half were single or divorced, 59% had not completed high school and 45% were not currently employed. Only 6% had been born in the United States, and 36% had resided in the United States five years or less. This sample's characteristics were roughly in concordance with demographic data reported on other urban Hispanic outpatient populations, with education level being somewhat lower and percentage unemployed slightly higher than previous studies have shown (Andrulis, 1977; Flores, 1978; Heiman & Kahn, 1975; Sue et al., 1978). Characteristics of the client sample are summarized in Table 1. Comparisons among the different Hispanic subgroups on demographic data will be presented in Chapter IV.

Table 1

Summary of Sample Characteristics

Characteristic	Client Sample (N = 155)
Hispanic Subgroup	
Puerto Rican	23%
Mexican	25%
Cuban	16%
Central American	17%
South American	19%
Time in U.S.	
5 years or less	36%
5 to 15 years	25%
Over 15 years	23%
Unknown	16%
Sex	
Male	41%
Female	59%
Age	
Range	16-58
Median	30
Religion	
Protestant	3%
Catholic	81%
Other	2%
None	4%
Unknown	10%
Marital Status	
Single	41%
Married	35%
Separated	12%
Divorced	10%
Widowed	2%

Table 1 (continued)

Characteristic	Client Sample (N = 155)
Educational Status	
None	1%
Less than 8th grade	21%
Completed 8th grade	14%
Some high school	23%
Completed high school	21%
Some college	13%
Completed college	4%
Business/Vocational training	1%
Unknown	2%
Employment Status	
Full-time	21%
Part-time	6%
Homemaker	19%
Full-time student	5%
Unemployed	45%
Retired	1%
Disabled	3%

Facility

Edgewater Uptown Community Mental Health Center (EUCMHC) is a multi-program multi-service community mental health agency located in a predominantly poor and ethnically diverse area of northern Chicago. The Ethnic Services Program of EUCMHC is primarily geared toward serving the mental health needs of the large Hispanic population of that community, although Native Americans and other ethnic populations are served through the program as well. The professional and paraprofessional staff of the program include many members who are bilingual/bicultural.

Procedure

Client data was obtained from the adult outpatient files that had been closed during fiscal years 1982 and 1983 in EUCMHC's Ethnic Services Program. Only those files of clients of Hispanic origin/descent were utilized. The data collected included demographic information (Hispanic subgroup, sex, age, religion, marital status, educational status, employment status), admission status (pre- or post-hospitalization, prior outpatient treatment), referral source, time resided in the United States, presenting problems, treatment modality received, number of agency contacts, type of termination, and type of exit referral.

A number of standard agency forms in the files were utilized. The demographic, admission status, and referral source data was taken from the agency's intake face sheet

in each file. When these data were absent from the intake face sheet, the standard intake summary was utilized. This intake summary, a structured narrative report, was also used to obtain the time in years and months that each client had resided in the United States.

Each client's number of contacts with the agency was totalled from the log of direct service contacts in his or her file. Because clients frequently received more than one type of treatment modality simultaneously while engaged at the agency (e.g., individual psychotherapy, medication evaluations, home visits), all contacts with the agency except phone calls were included in each client's total number of contacts.

Data pertaining to treatment modality received, type of termination, and type of exit referral from the agency were obtained from EUCMHC's standard closing summary. Since many clients received more than one treatment modality, up to three treatment modalities were recorded for each client.

All clients' presenting problems were drawn from the initial multi-disciplinary staffing notes. These notes were structured in format and included a section in which a client's current problems in living were listed and described. The first three problems described for each client were recorded in order, with the first problem listed considered to be the primary problem. These problems

were then classified according to a schedule of specific behavioral disturbances developed for use in this study. The schedule is composed of 44 items subdivided into disturbances pertaining to physical functioning, intellectual development, social relations, social performance, and other specific behavioral disturbances. The rationale for the use of this type of classification schema was based on Lorion's (1976) call for a strategy of examining symptoms in a way that the cultural implications of the problems presented by different ethnic groups may more easily be observed. He argued that the use of medical diagnoses often blurs meaning in ethnic comparison research. This schedule is presented in Appendix A.

Table 2 lists all the demographic and utilization variables analyzed in the present study, and details the manner in which they were categorized. Sample sizes differed for some of the variables because of missing data as well as elimination of cases due to manner of classification. Where possible, all available data were used.

Table 2

Classification of Demographic and Utilization Variables For Analyses

	n
Client Age (N = 155)	
16-25 years	48
26-35 years	57
36-45 years	31
46-58 years	19
Client Sex (N = 155)	
Male	63
Female	92
Hispanic Subgroup (N = 155)	
Puerto Rican	35
Mexican	39
Cuban	25
Central American	26
South American	30
Client Religion (N = 140)	
Catholic	126
Other	14
Client Marital Status (N = 155)	
Single/Divorced	79
Married/Separated	76
Client Education (N = 152)	
Less than High School	92
Completed High School or more	60
Client Employment Status (N = 155)	
Employed	41
Unemployed	68
Homemaker	14
Other	30

Table 2 (Continued)

	n
Time in United States (N = 130)	
Five years or less	57
Five years, one month to 10 years	26
Over 10 years	47
Admission Status (N = 155)	
Aftercare (posthospitalization)	43
Precare (no prior hospitalization)	86
Previous Outpatient Experience	26
Referral Source (N = 155)	
Self	54
Family/Friend	38
Medical	41
Nonmedical	22
Treatment Modality (N = 155)	
Individual psychotherapy only	68
Individual psychotherapy plus psychotropic medication	43
Individual psychotherapy, psychotropic medication, plus other (family group, etc.)	13
Individual psychotherapy plus other	19
Other only	12
Number of Agency Contacts (N = 154)	
One to five	56
Six to 15	65
Over 15	33
Termination Status (N = 128)	
Mutual Termination	18
Nonmutual Termination (Client withdrew or was hospitalized)	110

Table 2 (Continued)

	n
Referral Disposition (N = 155)	
No Referral	150
Referral	5

CHAPTER IV

RESULTS

Treatment Population Representation

Table 3 presents EUCHMC's total catchment area population figures and treatment population figures for fiscal years 1982 and 1983 broken down by ethnic groups. The number of unduplicated clients served during those years are reported for the total agency and for the Ethnic Services Program. In comparing the total agency population percentages with those of the catchment area population, it can be seen that Anglos were represented at the facility in approximately equal proportion to their catchment area population percentage (63.5% vs. 64.2%). Hispanics and Asians were underrepresented by 5.4% and 9%, respectively. Afro-Americans and Native Americans were overrepresented by 2.8% and 1.9%, respectively. Of the 493 Hispanic clients served by EUCMHC for the two year period, 305 were seen through the Ethnic Services Program.

Table 4 shows the Hispanic subgroup population proportions for both the catchment area Hispanic population and the Hispanic client cases that were closed during the two year period in the Ethnic Services Program. Because the catchment area population figures do not specify the

Table 3

Ethnic Group Composition of EUCMHC's Catchment Area and Ethnic Services Program Population

Group	Catchment Area		Total Agency Unduplicated Clients Served		Ethnic Services Program Unduplicated Clients Served	
	N	%[a]	N	%[b]	N	%[b]
Anglos	78,944	64.2	2,409	63.5	118	21.4
Hispanics	22,665	18.4	493	13.0	305	55.4
Afro-Americans	16,217	13.2	607	16.0	27	5.1
Native Americans	1,318	1.1	113	3.0	11	2.0
Asians	12,555	10.2	47	1.2	28	5.1
Others	--	--	123	3.2	61	11.1
	122,975	107.1	3,792	99.9	550	99.9

Note. The data in column 1 are from the Chicago Office of Planning, 1982. The data in columns 2 and 3 are from EUCMHC records.

[a]The percentages in this column total more than 100% because of duplicate recording (e.g., Hispanics also reporting themselves as White or Black).

[b]The percentages in this column fail to total 100% because of rounding.

Table 4

Hispanic Subgroup Composition of EUCMHC's Catchment Area and Ethnic Services Program Populations

Hispanic Subgroup	Catchment Area		Ethnic Services Program (Cases closed during FY 1982 and FY 1983)	
	N	%[a]	N	%[a]
Puerto Ricans	3,782	16.7	35	22.6
Mexicans	10,758	47.5	39	25.2
Cubans	2,304	10.2	25	16.1
Central Americans	unspecified		30	19.4
South Americans	unspecified		26	16.8
Other Hispanic Origin	5,783	25.5	--	--
	22,665	99.9	155	100.1

Note. The data in column 1 are from the Chicago Office of Planning, 1981.

[a]The percentages in this column do not total 100% because of rounding.

percentages of Central Americans and South Americans in the area, and include children and adolescents (who are not potential clients for the Ethnic Services Program) in the totals, direct comparison of the figures in the two columns is made difficult. Nonetheless, the data in Table 4 do suggest that Mexicans may have been underrepresented in comparison to the other Hispanic subgroups receiving services through the Ethnic Services Program. Mexicans make up 47.5% of the catchment area Hispanic population, but only 25.5% of the adult Hispanics whose cases were closed during the two year period were Mexican. Since the Ethnic Services data reported in Table 4 is of cases that were closed during the two year period, it is possible that different rates of termination, rather than actual underrepresentation, could account for this suggested descrepancy. For example, it may have been that Mexicans stayed in treatment longer, and thus had fewer closed cases during the examined time period. However, the comparisons of Hispanic subgroup termination rates (reported below) did not provide supportive evidence for this explanation.

Demographic Variables

Table 5 and Table 6 summarize the significant demographic differences among the Hispanic subgroups. Table 5 shows the mean and standard deviation comparisons for age, education level, and time lived in the United States. Since these data were continuous, analysis of variance was

Table 5

Hispanic Subgroup Mean (and Standard Deviation) Comparisons for Age, Education Level, and Time Resided in United States

	Puerto Ricans	Mexicans	Cubans	South Americans	Central Americans	df	F
Age	34.77(9.60)	30.77(9.69)	36.04(11.72)	31.96(9.88)	28.50(8.02)	4,150	2.86*
Education[a]	3.94(1.35)	3.28(1.47)	3.52(1.87)	5.12(1.34)	4.13(1.22)	4,150	6.92***
Time in U.S. (in years)	14.60(8.92)	13.14(12.00)	6.92(6.81)	6.06(4.92)	5.88(4.08)	4,111[b]	6.30**

[a]The classification scheme for education level was as follows: No formal education = 1; Less than 8th grade = 2; Completed 8th grade = 3; Some high school = 4; Completed high school = 5; Some college = 6; Completed college = 7; Graduate school = 8.

[b]Thirty-nine clients' length of residence was not determinable in exact number of years.

*p <.05

*p <.001

*p <.0001

Table 6

Employment Status Comparisons Among Hispanic Subgroups

Subgroup	Employed	Unemployed	Homemaker	Other	n	%
Puerto Ricans	19.5%	32.4%+	14.3%	10.0%+	35	22.9
Mexicans	24.2%	17.6%	28.6%	43.3%+	39	25.5
Cubans	2.4%+	26.5%+	14.3%	10.0%	24	15.7
South Americans	22.0%	10.3%	7.1%	30.0%+	26	17.0
Central Americans	31.7%+	13.2%	35.7%+	6.7%+	29	19.0
n	41	68	14	30	153[a]	

$\chi^2(12) = 36.55$, $p < .001$

+Indicates the largest observed-expected discrepancies.

[a]Employment status data were missing for two clients.

the method utilized to assess for subgroup differences. Significant differences among the subgroups were found for age, $F(4,150) = 2.86$, $p < .05$; education level, $F(4,150) = 6.92$, $p < .0001$; and time lived in the United States, $F(4,111) = 6.30$, $p < .001$. The a posteriori Duncan's multiple range test was utilized to compare all possible pairs of subgroup means for each of these significant findings. This procedure allowed a more specific delineation of which subgroup means were significantly different at the .05 significance level. For age, Puerto Ricans ($M = 34.77$) and Cubans ($M = 36.04$) were found to be significantly older than the Central Americans ($M = 28.50$). Educationally, the South Americans were significantly more highly educated than all other subgroups, with a mean education level slightly above the completion of high school ($M = 5.12$). In addition, the Central Americans ($M = 4.13$) were more highly educated than the Mexicans; i.e., more Central Americans had completed some high school or had graduated from high school than Mexicans ($M = 3.28$). The mean lengths of residence in the United States were significantly longer for the Mexicans ($M = 13.14$ years) and Puerto Ricans ($M = 14.60$ years) than for the Cubans, Central Americans, and South Americans, who had means of 6.92 years, 5.88 years, and 6.06 years, respectively.

Table 6 presents the Hispanic subgroups comparisons on employment status. Since these data were categorical,

the chi square statistic was utilized. As can be seen, employment status was significantly related to Hispanic subgroup, $\chi^2(12) = 36.55$, $p < .001$. Examination of the largest subgroup deviations from expectation yielded the observations that: a) Cubans and Puerto Ricans were relatively more often unemployed; b) Central Americans were relatively more often employed or homemakers; c) Mexicans and South Americans were more often classified as "other" (disabled, retired, or full-time students); and d) Puerto Ricans and Central Americans were less often classified as "other."

The relationship between Hispanic subgroup and marital status approached significance, $\chi^2(4) = 9.25$, $p < .10$. The largest deviations from expectation in this comparison were that the Cuban clients were relatively more often single or divorced, and the Puerto Rican clients were relatively more often married or separated. The chi square proportional analysis for this comparison can be found in Table 7.

No significant differences among the Hispanic subgroups were found on the demographic variables of sex or religion.

Utilization Variables

Admission status. Table 8 shows the Hispanic subgroup by admission status cell frequencies and chi square

Table 7

Marital Status Comparisons Among Hispanic Subgroups

Subgroup	Single/ Divorced	Married/ Separated	n	%
Puerto Ricans	16.5%+	28.9%+	35	22.6
Mexicans	26.6%	23.7%	39	25.2
Cubans	22.8%+	9.2%+	25	16.1
South Americans	12.7%	21.1%	26	16.8
Central Americans	21.5%	17.1%	30	19.4
n	79	76	155	

$\chi^2(4) = 9.25$, $p < .10$

+Indicates the largest observed-expected discrepancies.

Table 8

Comparison of Hispanic Subgroups on Admission Status

Subgroup	Aftercare	Precare	Previous Outpatient	n	%
Puerto Ricans	34.9%+	16.3%	23.1%	35	22.6
Mexicans	16.3%	31.4%+	19.2%	39	25.2
Cubans	25.6%+	11.6%	15.4%	25	16.1
South Americans	9.3%	17.4%	26.9%+	26	16.8
Central Americans	14.0%	23.3%	15.4%	30	19.4
n	43	86	26	155	

$\chi^2(8) = 15.50$, $p < .05$

+Indicates the largest observed-expected discrepancies.

value. Admission status was significantly related to Hispanic subgroup, $\chi^2(8) = 15.50$, $p < .05$. Puerto Ricans and Cubans were disproportionately more often aftercare clients (i.e., clients who had had one or more previous psychiatric hospitalizations). There were disproportionately more Mexicans who were precare clients (having had no previous psychiatric hospitalizations or outpatient treatment), and the South Americans had had previous outpatient treatment more often.

Primary presenting problem. When only the primary presenting problems of family discord, depression and anxiety, and delusions or hallucinations were considered, the relationship between Hispanic subgroup and primary presenting problem approached significance, $\chi^2(8) = 14.24$, $p < .10$. South Americans tended to present family discord as the primary problem relatively more often, and delusions or hallucinations as the primary problem relatively less often than the other subgroups. Central Americans presented delusions or hallucinations as the primary problem relatively more often than the other subgroups. The chi square proportional analysis for this comparison is presented in Table 9.

Overall presenting problem. When all presenting problems were considered, significant relationships among the Hispanic subgroups were found to exist for problems with mate/spouse, $\chi^2(4) = 16.30$, $p < .01$, and for problems

Table 9

Comparison of Hispanic Subgroups on Primary Presenting Problem

Subgroup	Family Discord	Depression and Anxiety	Delusions or Hallucinations	n	%
Puerto Ricans	15.8%	25.0%	27.3%	26	22.4
Mexicans	23.7%	25.0%	22.7%	28	24.1
Cubans	13.2%	19.6%	13.6%	19	16.4
South Americans	31.6%+	14.3%	0.0%+	20	17.2
Central Americans	15.8%	15.1%	36.4%+	23	19.8
n	38	56	22	116[a]	

$\chi^2(8) = 14.24$, $p < .10$

+Indicates the largest observed-expected discrepancies.

[a]39 clients had other primary presenting problems.

with immigration, $\chi^2(4) = 9.68$, $p < .05$. The frequency tables and chi square values for these comparisons are presented in Table 10. Cubans were relatively less likely, and South Americans more likely, to report problems with mate/spouse. Cubans were relatively more likely, and Puerto Ricans less likely, to report problems with immigration. No significant relationships were found for any other presenting problem and Hispanic subgroup, although there was a trend for South Americans to report relatively fewer problems with hallucinations, $\chi^2(4) = 9.12$, $p < .10$. The frequency table and chi square value for this subgroup comparison on presenting problem of hallucinations is presented in Table 11.

Termination status. The relationship between Hispanic subgroup and termination status (mutual client-therapist termination or client-initiated termination) approached significance, $\chi^2(4) = 7.92$, $p < .10$. Relatively fewer Puerto Ricans had mutual client-therapist terminations. Mexicans and Central Americans had relatively higher proportions of mutual terminations. The cell frequencies and chi square value for this comparison are presented in Table 12.

No relationships were found between the Hispanic subgroup variable and the utilization variables of referral source, treatment modality received, number of agency contacts, or exit referral disposition.

Table 10

Comparisons of Hispanic Subgroups on Presenting Problems with Mate/Spouse and Immigration

Subgroup	Problems With Mate/Spouse Present	Not Present	n	%	Problems With Immigration Present	Not Present	n	%
Puerto Ricans	24.1%	21.6%	35	22.6	5.0%+	25.2%	35	22.6
Mexicans	31.0%	21.6%	39	25.2	15.0%	26.7%	39	25.2
Cubans	1.7%+	24.7%	25	16.1	35.0%+	13.3%	25	16.1
South Americans	24.1%+	12.4%	26	16.8	20.0%	16.3%	26	16.8
Central Americans	19.0%	19.6%	30	19.4	25.0%	18.5%	30	19.4
n	58	97	155		20	135	155	
$\chi^2(4) = 16.30$, $p < .01$					$\chi^2(4) = 9.68$, $p < .05$			

+Indicates the largest observed-expected discrepancies

Table 11

Comparison of Hispanic Subgroups on Presenting Problem of Hallucinations

Subgroup	Hallucinations Present	Hallucinations Not Present	n	%
Puerto Ricans	26.9%	21.7%	35	22.6
Mexicans	19.2%	26.4%	39	25.2
Cubans	26.9%	14.0%	25	16.1
South Americans	0.0%+	20.2%	26	16.8
Central Americans	26.9%	17.8%	30	19.4
n	129	26	155	

$\chi^2(4) = 9.12$, $p < .10$

+Indicates largest observed-expected discrepancy.

Table 12

Comparison of Hispanic Subgroups on Termination Status

Subgroup	Termination Status Mutual	Non-Mutual	n	%
Puerto Ricans	5.6%+	26.4%	30	23.4
Mexicans	38.9%+	19.1%	28	21.9
Cubans	11.1%	18.2%	22	17.2
South Americans	11.1%	17.3%	21	16.4
Central Americans	33.3%+	19.1%	27	21.1
n	18	110	128[a]	

$\chi^2(4) = 7.92$, $p < .10$

+Indicates the largest observed-expected discrepancies.

[a]27 clients terminated under other circumstances, i.e., moved away, were referred elsewhere, etc.

Demographic Variables' Impact on Subgroup Utilization Differences

The demographic variables found to be significantly related to Hispanic subgroup were related by chi square proportional analyses with each of the utilization variables that were found to significantly differ for the subgroups. This was done in an attempt to assess the possibility that demographic differences in and of themselves may have been largely responsible for the significant subgroup differences found on utilization variables. The utilization variables found to be significantly related to Hispanic subgroup are listed below, and their relation to the subgroup-related demographic variables are described.

Admission status. As depicted in Table 13, admission status was found to be significantly related to marital status, $\chi^2(2) = 8.49$, $p < .05$, to employment status, $\chi^2(6) = 32.42$, $p < .0001$, and to education level, $\chi^2(2) = 7.99$, $p < .05$. Aftercare clients were disproportionately more often single or divorced and unemployed. Precare clients were disproportionately more often employed. More aftercare clients had not completed high school, and more clients who had had previous outpatient treatment had completed high school.

Primary presenting problem. Primary presenting problem was found to be significantly related to marital status, $\chi^2(2) = 11.56$, $p < .01$, and to employment status, $\chi^2(6) =$

Table 13

Relationships Between Marital Status, Employment Status, Education Level, and Admission Status

Marital Status	Aftercare	Precare	Previous Outpatient	n	%
Single/Divorced	69.8%+	43.0%	46.2%	79	51
Married/ Separated	30.2%+	57.0%	53.8%	76	49
n	43	86	26	155	

$\chi^2(2) = 8.49$, $p < .05$

Employment Status	Aftercare	Precare	Previous Outpatient	n	%
Employed	2.4%+	39.5%+	24.0%	41	26.8
Unemployed	73.8%+	31.4%+	40.0%	68	44.4
Homemaker	4.3%	8.1%	4.0%	14	9.2
Other	9.5%	20.9%	32.0%	30	19.6
n	42	86	25	153	

$\chi^2(6) = 32.42$, $p < .0001$

Table 13 (Continued)

Education Level	Aftercare	Precare	Previous Outpatient	n	%
Less Than High School	76.7%+	57.1%	44.0%	92	60.5
Completed High School or More	23.3%+	42.9%	56.0%+	60	39.5
n	43	84	25	152	

$\chi^2(2) = 7.99$, $p < .05$

+Indicates largest observed-expected discrepancies.

16.92, $p < .01$. Those clients presenting primary problems of delusions or hallucinations were more likely to be divorced or single. Clients presenting family discord as the primary problem were more often employed or "other" (retired, disabled, or full-time students). Clients presenting primary problems of delusions or hallucinations were disproportionately unemployed, and rarely were in the employment classification of "other." These analyses are shown in Table 14.

Overall presenting problems. Problems with mate/spouse were significantly related to marital status, $\chi^2(1) = 11.34$, $p < .001$, and to employment status, $\chi^2(3) = 18.47$, $p < .001$. These analyses are presented in Table 15. Clients presenting problems with mate/spouse were relatively more often married or separated and unemployed.

Problems with immigration were significantly related to age, $\chi^2(3) = 10.59$, $p < .05$, and to time resided in the United States, $\chi^2(2) = 12.37$, $p < .01$, as is shown in Table 16. Examination of the actual cell frequencies in these tables revealed disproportionately more problems with immigration to be presented by clients who were 26-35, and less by those who were 16-25 or 46 or older. Also, more clients reported problems with immigration when they had been in this country five years or less or, to a lesser extent, when they had resided in this country over 10 years.

None of the subgroup-related demographic variables

Table 14

Relation Between Primary Presenting Problem, Marital Status, and Employment Status

Marital Status	Family Discord	Depression and Anxiety	Delusions and Hallucinations	n	%
Single/ Divorced	36.8%	37.5%	77.3%+	52	44.8
Married/ Separated	63.2%	62.5	22.7%+	64	55.2
n	38	56	22	116	

$\chi^2(2) = 11.56$, $p < .01$

Employment Status	Family Discord	Depression and Anxiety	Delusions and Hallucinations	n	%
Employed	31.6%+	19.6%	14.3%	26	22.6
Unemployed	21.1%+	46.4%	71.4%+	49	42.6
Homemaker	10.5%	12.5%	9.5%	13	11.3
Other	36.8%+	21.4%	4.8%+	27	23.5
n	38	56	21	115	

$\chi^2(6) = 16.92$, $p < .01$

+Indicates largest observed-expected discrepancies.

Table 15

Relationship Between Marital Status, Employment Status, and Presenting Problems with Mate/Spouse

Admission Status	Problems with Mate/Spouse Present	Not Present	n	%
Single/ Divorced	25%+	58.8%	79	51.0
Married/ Separated	75%+	41.2%	76	49.0
n	36	119	155	

$\chi^2(1) = 11.34$, $p < .001$

Employment Status	Present	Not Present	n	%
Employed	50%+	19.7%+	41	26.8
Unemployed	25%+	50.4%	68	44.4
Homemaker	0.0%	12.0%	14	9.2
Other	25.0%	17.9%	30	19.6
n	36	117	153	

$\chi^2(3) = 18.47$, $p < .001$

+Indicates the largest observed-expected discrepancies.

Table 16

Relationship Between Age, Time in United States, and Presenting Problems with Immigration

Age	Problem with Immigration Present	Not Present	n	%
16 - 25	7.7%+	33.1%	48	31.0
26 - 35	76.9%+	33.1%	57	36.8
36 - 45	15.4%	20.4%	31	20.0
46 - 58	0.0%+	13.4%	19	12.3
n	13	142	155	

$\chi^2(3) = 10.59$, $p < .05$

Time (years)	Present	Not Present	n	%
5 or Less	91.7%+	39.0%	57	43.8
5 - 10	0.0%+	22.0%	26	20.0
Over 10	8.3%+	39.0%	47	36.2
n	12	118	130	

$\chi^2(2) = 12.37$, $p < .01$

+Indicates the largest observed-expected discrepancies.

were found to be related to presenting problems of hallucinations.

Termination status. None of the subgroup-related demographic variables were found to be related to termination status.

The existence of these significant relationships between subgroup-related demographic variables and subgroup-related utilization variables makes interpretation of the Hispanic subgroup differences for utilization variables difficult. It is possible that in some cases no main effect for Hispanic subgroup exists, or that interactions between Hispanic subgroup and demographic variables are present. With continuous data this would be essentially a multivariate problem which could be addressed through appropriate analysis of variance or regression analysis procedures. However, the categorical nature of these data prevents further statistical investigations. Attempts to integrate the significant Hispanic subgroup by utilization variable findings with the significant demographic by utilization variable findings will be made in Chapter V.

Overall Utilization Patterns

Few Hispanic subgroup differences were found on the utilization variables. Because of this it was felt that it would be of interest to look at how this Hispanic sample stood as a whole on the utilization variables examined in this study. Table 17 presents the sample's percentage

Table 17

Total Sample Percentages for Each Utilization Variable

Variable	%
Admission Status (n = 155)	
Aftercare	27.7
Precare	55.5
Previous Outpatient	16.8
Referral Source (n = 155)	
Self	34.8
Family/Friend	24.5
Medical	26.5
Nonmedical	14.2
Primary Presenting Problem (n = 155)	
Family Discord	24.5
Depression and Anxiety	36.1
Delusions or Hallucinations	14.2
Other	25.2
All Presenting Problems (n = 309)[a]	
Sleeping problems	14.6
Problems with mate/spouse	11.6
Depressed mood/inferiority, guilt	10.4
Anxiety, nervousness	8.1
Problems with child	5.2
Problems with other family	4.5
Hallucinations	3.9
Problems with job	3.6
Problems with other people	3.2
Dependency, clinging	3.2
Other	31.7

Table 17 (Continued

Variable	%
Treatment Modality (n = 155)	
Individual psychotherapy alone	43.9
Individual psychotherapy plus psychotropic medication	27.7
Individual psychotherapy plus other (group, family, couple, etc.)	12.3
Individual psychotherapy plus psychotropic medication plus other	8.4
Other alone	7.7
Number of Agency Contacts (n = 154)	
One	9.7
2-5	26.6
6-15	42.2
16 or more	21.4
Median	8.64
Range	1-93
Termination Status (n = 155)	
Client initiated	70.0
Mutual termination	11.6
Other (client death, client moved, client referred to other facility)	18.7
Referral Disposition (n = 155)	
None	96.8
Other	3.2

[a]A total of 309 presenting problems were reported.

breakdown on each utilization variable. The most frequent admission status was precare (55.5%) and the most common referral source was self (34.8%). Depression and anxiety were the most frequent primary presenting problems (36.1%), and the most frequently reported problem overall was difficulty in sleeping (14.6%). More clients (43.9%) received individual psychotherapy alone than any other type(s) of treatment. The median number of agency contacts was 8.64, and the range was from one to 93. The majority (70.0%) of client terminations were client initiated, and 96.8% of clients left the agency with a referral disposition of "none."

In examining this sample as a whole, it was also felt that the following three questions were of particular interest in light of the previous literature on Hispanic utilization of mental health services: a) What percentage of this sample terminated treatment after the first session, and how does this compare to previously reported rates?; b) Were there any differences in termination status for the different treatment modalities rendered?; and c) Were there any relationships between demographics and termination status for this sample?

Table 17 shows 9.7% of the clients to have left treatment after the first session. A chi square analysis using an expected value of 42% (the rate reported by Sue et al., 1978) found this rate to be significantly less

than Sue et al.'s findings, $\chi^2(1) = 65.79$, $p < .0001$.

A chi square proportional analysis of those clients who did and did not leave the agency by mutual termination for each treatment modality category found the relationship between treatment modality and termination status nonsignificant, $\chi^2(4) = 1.96$, $p < .05$.

The investigation of demographic relationships to termination status found a significant relationship only for sex, $\chi^2(1) = 6.88$, $p < .01$, with disproportionately fewer males having mutual client-therapist terminations. The frequency table for this comparison and the resultant chi square value are shown in Table 18.

Table 18

Relation Between Client Sex and Termination Status

Sex	Termination Status Mutual	Nonmutual	n	%
Male	11.1%+	47.3%	54	42.2
Female	88.9%+	52.7%	74	57.8
n	18	110	128[a]	

$\chi^2(1) = 6.88$, $p < .01$

[a]Twenty-seven clients had other termination status (client moved, client died, client was referred to other facility, therapist left agency).

+Indicates largest observed-expected descrepancies.

CHAPTER V

DISCUSSION

This study's findings with regard to ethnic group treatment population representation are similar to those previously reported in the literature. Hispanics and Asians were underrepresented while Native Americans and, to a lesser extent, Afro-Americans were overrepresented when compared to their catchment area populations. It is noteworthy that these patterns emerged in a community mental health center in Chicago, which is geographically distant from the sites where these patterns have already been reported. With respect to this it may be said that this study's findings enhance the generalizability of these previously discovered ethnic group representation patterns in community mental health facilities.

The reasons for the particular patterns of underrepresentation for Hispanics and Asians, and overrepresentation for Afro-Americans and Native Americans remain unclear, but it is important to note that those ethnic groups who were overrepresented were indigenous to the United States, and those who were underrepresented were predominantly foreign immigrants. This would seem to support the argument that language factors and cultural differences from the dominant

society (particularly the degree of reliance on the extended family as a source of emotional support) may be especially important considerations in the understanding of ethnic group mental health utilization patterns. For example, it may be that Native Americans and Afro-Americans have been overrepresented in treatment populations because of the stresses associated with minority status, coupled with a lesser extent of extended family support than that which occurs within the dominant culture. On the other hand, past literature has suggested that, while experiencing the stresses of immigrant minority status, Hispanics and Asians may have a higher degree of extended family support in their cultures which protects them from needing or seeking professional help. Moreover, the language barriers which Hispanics and Asians also experience may further inhibit them from seeking help when it is actually needed. It may also be possible that there are other characteristics associated with immigrant status that operate to lessen the need or proclivity to seek professional mental health services. That is, there may be self-selection factors that distinguish between those who immigrate and those who do not. Those who immigrate may have more of certain skills, resources, and coping capacities, and thus might experience a lower incidence rate of psychological problems or have a greater resistance to seeking outside professional help. While the idea that Hispanics may experience lower

incidence rates of psychological problems has not been generally supported in the literature, self-selection factors could still conceivably operate to decrease the willingness to seek emotional support from Anglo professionals.

What is clear is that minority status per se is not predictive of over- or underrepresentation. More investigations into the mental health needs, alternative resources, knowledge about mental health resources, attitudes toward mental health treatment, and responsiveness of services for each ethnic group seem to be necessary in order to more fully understand these representation patterns.

With regard to treatment representation levels for the specific Hispanic subgroups, this study revealed the possibility that Mexican Americans were the most underrepresented among them. Mexicans were the only Hispanic subgroup to have a treatment population percentage below their proportion of the catchment area's Hispanic population. The available census data prevented direct comparisons between the percentage of adults in the catchment area for each subgroup and the Ethnic Services Program population. If there were more Mexican children and adolescents in the catchment area than for the other subgroups, the level of underrepresentation suggested by these data would be inflated, since the Ethnic Services Program only serves adults. There seems to be little actual reason to believe

that this might be the case, however. Mexicans were not found to differ from the other subgroups on marital status, which suggests that the Mexican subgroup did not differ from the other subgroups in number of family units. Also, all subgroups were predominantly Catholic, which implies a cultural similarity among the subgroups with regard to their beliefs and practices associated with family size. Therefore, since it seems likely that the available population figures for each subgroup are relatively accurate for the adult percentages in each subgroup, the findings of this study may indicate a specific Mexican underrepresentation rate. Since most studies reporting Hispanic underrepresentation in treatment populations have been conducted with Mexican populations, such a phenomenon would question the generalizability of the findings of underrepresentation to other Hispanic subgroups.

It was the focus of this study to examine how Hispanic subgroups may utilize mental health services differently. Few subgroup differences were found on the utilization variables. Of those utilization differences that were discovered, most were more strongly related to subgroup demographic differences, as indicated by lower probability levels. This suggests that the demographic differences in and of themselves may be the major factors accounting for the utilization findings.

With regard to the admission status differences,

Puerto Ricans and Cubans were found disproportionately to be aftercare clients, and to suffer from unemployment more often than the other subgroups. However, aftercare status was more strongly related to being unemployed. Thus, whether the Puerto Rican and Cuban clients were more often aftercare clients because of higher mental health risks associated with unemployment, or that, being aftercare clients, they had more difficulties with finding or maintaining employment, or if some other variable or variables caused both these outcomes is impossible to determine from these data.

More South Americans had had previous outpatient therapy, and the South Americans as a group were the most highly educated among the subgroups. Since higher education level was strongly related to having had prior outpatient treatment, it is probable that the South American difference on admission status was due to this relationship rather than to any specific South American cultural characteristics. The finding that Mexicans were disproportionately high in numbers among the precare clients did not seem clouded by demographic factors, since Mexicans did not differ from the other subgroups on those demographic variables found to be related to admission status.

When looking at primary presenting problem patterns, there was a nonsignificant trend for Central Americans to present delusions or hallucinations as the primary problem

more often which did not seem to be related to their demographic standing. However, the trend for South Americans to present the primary problem of family discord more often, and of delusions and hallucinations less often, may have been due to their disproportionately high representation in the employment category of "other." Those clients who were in this category presented significantly more primary problems of family discord and less of delusions and hallucinations. Whether specific South American characteristics above and beyond demographic differences led to this primary presenting problem pattern, or the South Americans' situation of being retired, disabled, or full-time students more often contributed to this pattern more strongly is difficult to determine. Some light was shed on this matter in the analysis of the findings that Cubans were less likely, and South Americans were more likely to report problems with mate/spouse when all presenting problems were considered. Being employed (not retired, disabled, or a full-time student), and married or separated related positively to this presenting problem. Since South Americans were not more often employed or married or separated relative to the other subgroups, it seems possible that some specific characteristics of South Americans contribute to more frequent marital difficulties. The finding that Cubans presented fewer problems with mate/spouse, on the other hand, seemed to be a direct consequence of their demographic standing of

more often being single or divorced and unemployed.

The trend for South Americans to present fewer delusions or hallucinations also seemed to be free of demographically related differences. Although the finding only approached significance, it offers some additional support for the notion that South Americans may present problems which reflect differences from the other subgroups that are not due to demographic differences alone.

When the clients of this study presented problems with immigration, the nature of these problems much more often pertained to feelings of alienation, of being uncomfortable with the stresses presented them by American culture, and to job discrimination, than to legal problems with immigrating. That Cubans presented more, and Puerto Ricans presented fewer of these problems with immigration seems difficult to interpret by subgroup demographic differences. This is due in part to the fact that the meaning of the demographic relationships to the presentation of these problems is not clear. Why more clients who were 26-35 or older than 45 would present more problems with immigration is not easily understood. And while it is understandable that clients who had been in this country for five years or less would present more problems with immigration, why clients who had been in the country for over 10 years would do so is puzzling. It may be that those clients who had recently immigrated experienced more problems associated

with feelings of alienation, and that those who had been in this country 10 years or more experienced a more general disillusionment with their situation in this country. However, the data were not sufficiently detailed to allow an examination of this possibility.

What may be most noteworthy about the findings on the presentation of problems with immigration is that the Puerto Ricans, but not the Mexicans, presented these problems less frequently. This occurred even though both groups had been in this country for the longest average length of time. One possibility for this is that there were more Mexicans who had recently immigrated. This is suggested by the fact that there was more variability in the length of residence in this country for Mexicans. Another possibility is that Puerto Ricans may experience less actual difficulty in coming to this country because of their already having the status of being United States citizens. Similar to this situation is the fact that the Cubans reported more immigration problems than the Central or South Americans, even though there was no significant differences in their average lengths of United States residence.

As for the termination status findings, there was a trend approaching significance for Puerto Ricans to have had fewer mutual client-therapist terminations, and for Mexicans and Central Americans to have had more such

terminations. No demographic differences were predictive of termination status. It is interesting to note that Mexicans and Puerto Ricans differed on this variable, for both groups had had presumably longer acculturation periods in this country. Acculturation has been shown to be predictive of more frequent mental health service utilization. Also, the fact that Mexicans and Central Americans may have had more successful treatment experiences, as suggested by this finding, is interesting in that these two subgroups had significantly different education levels. More frequent mental health utilization has also been shown to be associated with higher levels of education among Hispanics. One possible explanation for these findings is that the client-therapist relationships were more positive for the Mexican and Central American clients, and less so for the Puerto Rican clients. This may have been a result of therapist characteristics, such as differing degrees of familiarity or comfort with different Hispanic subgroup cultural characteristics.

In summing up this study's findings with regard to the Hispanic subgroup demographic and utilization variable differences, a number of demographic differences were discovered among the subgroups which were related to most of the few utilization differences found. In this regard one weakness of this study lies in the fact that the relative strengths of these various relationships could not be

directly assessed because of the categorical nature of the data. The subgroup demographic differences and those subgroup utilization differences which did not seem strongly related to demographics (and thus potentially reflecting more purely cultural differences) are summarized in Table 19.

While the demographic differences were not systematic for any one subgroup, such differences do suggest that from the outset the subgroups present different types of clients. The Cuban clients were on the average older, and were more often unemployed and single or divorced. The Mexican clients had the lowest average level of education, and had a longer average length of residence in this country. The Puerto Rican clients on the average were older, had resided in this country longer, were more often unemployed, and were more often married or separated. The South Americans and Central Americans had the highest levels of education, and the Central Americans were more often employed and/or homemakers. These various findings support to some extent claims made in the literature that the Hispanic subgroups in this country are different in socioeconomic factors, immigration histories, and responses to the stresses presented by living in this country. A number of clinical implications also arise from these findings. The Cubans, for example, may be in more need of services which actively help locate outside community sources of support. Special

Table 19

Summary of Demographic and Utilization Variable Differences

VARIABLE	Puerto Ricans	Mexicans	Cubans	Central Americans	South Americans
AGE	Older	---	Older	Younger	---
EDUCATION	---	Less	---	More	More
EMPLOYED	Less	---	Less	More	---
MARITAL STATUS	More Married[a]	---	Less Married[a]	---	---
TIME IN COUNTRY	Longer	Longer	---	---	---
ADMISSION STATUS	---	More Precare	---	---	---
PRIMARY PRESENTING PROBLEM	---	---	---	More delusions, hallucinations	---
OVERALL PROBLEMS	Less problems with immigration	---	More problems with immigration	---	More marital discord; Less delusions, hallucinations[a]
TERMINATION STATUS	Less mutual terminations[a]	More mutual terminations[a]	---	More mutual terminations[a]	---

[a]These relationships only approached significance.

pre-therapy training programs, such as those described by Hoehn-Saric, Frank, Imber, Nash, Stone, and Battle (1964), with the purpose of enhancing the congruity of client-therapist expectations may be appropriate for those groups who have lower educational levels. Those subgroups who have larger numbers of recent immigrants might be in more need of outreach and community support services.

The utilization differences relatively free of demographic variable confounding include: a) Mexicans were more often precare clients; b) Central Americans tended to present delusions or hallucinations as the primary problem more often (although this only approached significance); c) South Americans presented more marital difficulties and had a nonsignificant tendency to present less problems of delusions and hallucinations; d) Cubans presented more, and Puerto Ricans presented fewer, problems with immigration; and e) there was a trend for Puerto Ricans to have fewer, and for Mexicans and Central Americans to have more, mutual client-therapist terminations. None of the literature that was reviewed offers much help in explaining these findings or relating them to previously discovered subgroup differences. While it is possible that these findings were due to chance, it is also possible that these findings reflect cultural-specific characteristics or problem areas. Investigation into this latter possibility seems warranted. Further research would be helpful, for

example, in determining why Cubans may find the immigration experience more problemmatic. If this phenomenon was due, for example, to a large number of Cubans in the area having come to this country via the recent refugee floatillas, such information could be utilized in the development of outreach programs for that specific population.

The lack of significant differences among the subgroups on the variables of referral source, most presenting problems, treatment modalities received, number of agency contacts, and referral disposition indicates the Hispanic clients seen at EUCMHC may be more similar than dissimilar in how they approach service, how they are rendered services by staff, and how they respond to the services offered.

This study found this Hispanic sample as a whole to leave therapy after the first session (and in traditional views, to therefore obtain minimal benefits from treatment) at significantly lower rates than have previously been reported in the literature. Taking Sue's (1978) stance that high dropout rates reflect unresponsive services, this finding may be indicative of a higher degree of responsiveness to the specific needs of the Hispanic clients in EUCMHC's Ethnic Services Program. Furthermore, the finding here of a median number of agency contacts of 8.64 suggests a responsiveness of service equal to that received by non-ethnic populations. In a major review of studies reporting

on length of stay in psychotherapy, Garfield (1978) concluded that of patients who were offered and accepted psychotherapy, the median length of stay ranged from three to 12 visits, with a clustering around six sessions. The fact that there were proportional numbers of mutual client-therapist terminations (suggesting therapeutic success) for the various treatment modalities that were rendered suggests that the Hispanic clients also received services equally relevant to the problems they presented. The finding that males had significantly fewer mutual client-therapist terminations offers the possibility that the Hispanic males may have experienced fewer psychotherapeutic successes. Several writers in the literature have suggested that because of the characteristics of dominance and self-reliance ascribed to the male role in Hispanic culture, Hispanic males may find psychotherapy particularly threatening or to be a sign of weakness. Further investigation into whether Hispanic males actually have fewer psychotherapeutic successes (and how the traditional sex role for Hispanic men may contribute to this) would be a logical extension of this particular finding.

REFERENCES

Abad, V., Ramos, J., & Boyce, E. (1974). A model for delivery of mental health services to Spanish-speaking minorities. American Journal of Orthopsychiatry, 44, 584-595.

Acosta, F. X. (1977). Ethnic variables in psychotherapy: The Mexican American. In J. L. Martinez, Jr. (Ed.), Chicago psychology. New York: Academic Press.

Acosta, F. X. (1979). Barriers between mental health services and Mexican Americans: An examination of a paradox. American Journal of Community Psychology, 7, 503-520.

Acosta, F. X., & Sheehan, J. C. (1976). Psychotherapist ethnicity and expertise as determinants of self-disclosure. In M. R. Miranda (Ed.), Psychotherapy with the Spanish-speaking: Issues in research and service delivery. Los Angeles: Spanish Speaking Mental Health Research Center, University of California at Los Angeles, Monograph No. 3.

Andrulis, D. (1977). Ethnicity as a variable in the utilization and referral patterns of a comprehensive mental health center. Journal of Community Psychology, 5, 231-237.

Arce, A. A. (1982). Psychiatric training issues: The Puerto Rican perspective. American Journal of Psychiatry, 139, 461-465.

Barrera, Jr., M. (1978). Mexican-American mental health service utilization: A critical examination of some proposed variables. Community Mental Health Journal, 14, 35-45.

Chicago Department of Planning. (1982). 1980 census reports: City of Chicago population (Part 1). Chicago Department of Planning.

Christensen, E. W. (1975). Counseling Puerto Ricans: Some cultural considerations. Personnel and Guidance Journal, 53, 349-356.

Cobb, C. W. (1972). Community mental health services and the lower socioeconomic class: A summary of research literature on outpatient treatment (1963-1969). American Journal of Orthopsychiatry, 42, 404-414.

Delgado, M., & Scott, J. F. (1979). Strategic intervention: A mental health program for the Hispanic community. Journal of Community Psychology, 7, 187-197.

Fabrega, Jr., J., Swartz, J. D., & Wallace, C. A. (1968). Ethnic differences in psychopathology: II. Specific differences with emphasis on a Mexican American group. Journal of Psychiatric Research, 6, 221-235.

Flores, J. L. (1978). The utilization of a community mental health service by Mexican Americans. International Journal of Social Psychiatry, 24, 271-275.

Garfield, S. L. (1978). Research on client variables in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change: An empirical analysis (2nd ed.). New York: John Wiley & Sons.

Gil, R. M. (1981). Cultural attitudes toward mental illness among Puerto Rican migrant women and their relationship to the utilization of outpatient mental health services (Doctoral Dissertation, Adelphi University, School of Social Work, 1980). Dissertation Abstracts International, 41 (7-B), 2557.

Gomez, A. G. (1976). Some considerations in structuring human services for the Spanish-speaking population of the United States. International Journal of Mental Health, 5, 60-68.

Heiman, E. M., & Kahn, M. W. (1975). Mental health patients in a barrio health center. International Journal of Social Psychiatry, 21, 197-206.

Hoehn-Saric, R., Frank, J. C., Imber, D. S., Nash, E. H., Stone, A. R., & Battle, C. C. (1964). Systematic preparation of patients for psychotherapy. I. Effects on therapy behavior and outcome. Journal of Psychiatric Research, 2, 267-281.

Jaco, E. G. (1960). The social epidemiology of mental disorders: A psychiatric survey of Texas. New York: Russell Sage Foundation.

Kahn, M. W., & Heiman, E. M. (1979). Factors associated with number of treatment interviews of patients from a barrio-neighborhood mental health service: A cross-validation. American Journal of Community Psychology, 7, 231-235.

Karno, M. (1966). The enigma of ethnicity in a psychiatric clinic. Archives of General Psychiatry, 14, 516-520.

Karno, M., & Edgarton, R. B. (1969). Perception of mental illness in a Mexican American community. Archives of General Psychiatry, 20, 233-238.

Keefe, S. E., & Casas, J. M. (1980). Mexican Americans and mental health: A selected review and recommendations for mental health service delivery. American Journal of Community Psychology, 8, 303-326.

Keefe, S. E., Padilla, A. M., & Carlos, M. L. (1978). Emotional support systems in two cultures: A comparison of Mexican Americans and Anglo Americans. Los Angeles: Spanish Speaking Mental Health Research Center, University of California at Los Angeles, Occasional Paper No. 7.

Kline, L. Y. (1969). Some factors in the psychiatric treatment of Spanish Americans. American Journal of Psychiatry, 125, 1674-1681.

Lorion, R. P. (1973). Socioeconomic status and traditional treatment approaches reconsidered. Psychological Bulletin, 79, 263-270.

Lorion, R. P. (1974). Patient and therapist variables in the treatment of low-income patients. Psychological Bulletin, 81, 344-354.

Lorion, R. P. (1976). Ethnicity and mental health: An empirical obstacle course. International Journal of Mental Health, 5, 16-25.

Madsen, W. (1979). Mexican Americans and Anglo Americans: A comparative study of mental health in Texas. In S. C. Plog & R. B. Edgarton (Eds.), Changing perspectives in mental illness. New York: Holt, Rinehart & Winston.

Martinez, Jr., J. L. (Ed.). (1977). Chicano psychology. New York: Academic Press.

Montijo, J. (1975). The Puerto Rican client. Professional Psychology, 6, 475-477.

Padilla, A. M., Padilla, E., Morales, A. Olmedo, S., & Ramirez, R. (1978). Inhalent, marijuana, and alcohol abuse among barrio children and adolescents. Los Angeles: Spanish Speaking Mental Health Research Center, University of California at Los Angeles, Monograph No. 6.

Padilla, A. M., & Ruiz, R. A. (1973). Latino mental health: A reivew of the literature. Washington, D.C.: National Institute of Mental Health, U.S. Government Printing Office.

Padilla, A. M., Ruiz, R. A., & Alvarez, R. (1975). Community mental health services for the Spanish-speaking/surnamed population. American Psychologist, 30, 892-905.

Pokorny, A. D., & Overall, J. E. (1970). Relationship of psychopathology to age, sex, ethnicity, education, and marital status in state hospital patients. Journal of Psychiatric Research, 7, 143-152.

Rabkin, J. G. (1979). Ethnic density and psychiatric hospitalizations: Hazards of minority status. American Journal of Psychiatry, 136, 1562-1566.

Roberts, R. E. (1980). Prevalence of psychological distress among Mexican-Americans. Journal of Health and Social Behavior, 21, 134-145.

Roll, S., Millen, L., & Martinez, R. (1980). Common errors in psychotherapy with Chicanos: Extrapolations from research and clinical experience. Psychotherapy: Theory, Research, and Practice, 17, 158-168.

Rosado, Jr., J.W. (1980). Important psychocultural factors in the delivery of mental health services to lower-class Puerto Rican clients: A review of recent studies. Journal of Community Psychology, 8, 215-226.

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. American Psychologist, 32, 616-624.

Sue, S. Allen, D. B., & Conaway, L. (1978). The responsiveness and equality of mental health care to Chicanos and Native Americans. American Journal of Community Psychology, 6, 137-146.

Szapocznik, J., Kurtines, W., & Hanna, H. (1979). Comparison of Cuban and Anglo-American cultural values in a clinical population. Journal of Consulting and Clinical Psychology, 47, 623-624.

Szapocznik, J., Scopetta, M. A., Aranalde, N. A., & Kurtines, W. M. (1978). Cuban value structure: Treatment implications. Journal of Consulting and Clinical Psychology, 46, 961-970.

Szapocznik, J. Scopetta, M. A., & King, O. E. (1978). Theory and practice in matching treatment to the special characteristics and problems of Cuban immigrants. Journal of Community Psychology, 6, 112-122.

Torres, W. J. (1981). A comparison of Puerto Rican and Anglo concepts of appropriate mental health service utilization (Doctoral Dissertation, University of Colorado at Boulder, 1980). Dissertation Abstracts International, 42 (1-B), 393-394.

Torrey, E. F. (1972). The mind game: Witchdoctors and psychiatrists. New York: Emerson Hall.

U.S. Bureau of Census. (1981). 1980 census of population: General population characteristics, U.S. summary (Vol. 1, Chapter B, Part 1). Washington, D.C.: U.S. Government Printing Office.

Yamamoto, J., James, Q. C., & Palley, N. (1978). Cultural problems in psychiatric therapy. Archives of General Psychiatry, 19, 45-49.

APPENDIX A

BEHAVIORAL DISTURBANCE SCHEDULE - Coding Format

Physical Function Disturbance

01 Sleeping problem
02 Eating problem
03 Eneuresis, soiling
04 Seizures, convulsions
05 Speech problems
06 Other physical problems

Intellectual Development

07 Inadequate

Social Relations Disturbances

08 With child
09 With mate, spouse
10 With other family
11 With other people
12 With authority
13 Problems with immigration experience

Social Performance Disturbances

14 Job
15 School
16 Housekeeping

Other Behavioral Disturbances

17 Suicidal thoughts
18 Suicidal acts, gestures
19 Anxiety, nervousness
20 Fears, phobias
21 Depressed mood, guilt
22 Low self-esteem
23 Obsessions, compulsions
24 Social withdrawal, isolation
25 Somatic conerns, hypochondriasis
26 Dependency, clinging
27 Grandiosity
28 Suspicion, persecution
29 Delusions
30 Hallucinations
31 Anger, belligerence, negativism
32 Assaultive acts
33 Alcohol abuse
34 Sexual problems
35 Narcotics; other drugs
36 Antisocial acts, attitudes

Other Behavioral Disturbances (continued)

37 Agitation, hyperactivity
38 Disorientation, impaired memory
39 Speech disorganization, incoherence
40 Blunted affect
41 Inappropriate affect, appearance, behavior
42 Daily routine, leisure time impairment
43 Psychomotor retardation
44 Psychotropic medication side effect, reaction

APPROVAL SHEET

The thesis submitted by Silas Gregory Gilliam has been read and approved by the following Committee:

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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

4/5/84
Date

Alan S. DeWolfe
Director's Signature